DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-011

2. STATE: UTAH

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
JANUARY 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 1902(a)(13)(A) OF THE ACT

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ 0
b. FFY 2004 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19D SECTION 900

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19D SECTION 900

10. SUBJECT OF AMENDMENT:
REDISTRIBUTION -
NURSING FACILITY FUNDING

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL: Rod Betit

13. TYPED NAME:
ROD L. BETIT

14. TITLE:
EXECUTIVE DIRECTOR, UTAH DEPT. OF HEALTH

15. DATE SUBMITTED:

16. RETURN TO:
ROD L. BETIT
UTAH DEPARTMENT OF HEALTH
PO BOX 143102
SALT LAKE CITY, UT 84114-3102

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 3, 2003

18. DATE APPROVED: JAN 12 2004

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JAN - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:
Brown for Smith.

21. TYPED NAME: Charlene Brown

22. TITLE:
Deputy Director, CMSO

23. REMARKS:

POSTMARK: March 31, 2003

FORM HCFA-179 (07-92)

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900 RATE SETTING FOR NFs

900 GENERAL INFORMATION

Rate setting is completed by the Division of Health Care Financing (DHCF). Cost and utilization data is evaluated from facility cost profiles. The annual Medicaid budget requests includes inflation factors for nursing facilities based on the Producer Price Index published by the U.S. Department of Labor, Bureau of Labor Statistics. The actual inflation will be established by the Utah State Legislature based on economic trends and conditions. Consideration will be given to the inflation adjustments given in prior years relative to the Producer Price Index.

920 RATE SETTING

Effective January 1, 2003, the base line per diem rate for all patients in the facility consists of: 1) a RUGs component, 2) a fixed rate component, and (3) a property differential component. The components are based on historical costs reported on facility cost profiles (cost reports). The historical cost calculation, although utilizing the facility cost profiles, will be adjusted to account for Medicare payments (netted from total costs), and certain "add on" payments including, intensive skilled payment enhancements, specialized rehabilitation services (SRS) payment enhancements, behaviorally challenging payments enhancements and finally any other enhancement payments that Medicaid may initiate in the future. Historical costs, except for property related costs, are arrayed for each cost center and the 50% percentile is used as the "reasonable costs" base line. Base line per diem rates are the per diem payment rates net of special "add-ons" for individual patients, as discussed above.

920 b. BEHAVORIALLY CHALLENGING PATIENT ADD-ON

This "add on" which was effective July 1, 2003, was designed to recognize and compensate providers for patients that require an inordinate amount of resources due to the intensive labor involved in their care.

Behaviorally challenging patients are defined as follows:

Behaviorally complex resident means a Long Term Care resident with a severe medically based behavior disorder (including but not limited to Traumatic Brain Injury, Dementia, Alzheimer, Huntington's Chorea) which causes diminished capacity for judgment, retention of information and/or decision making skills, or a resident , who meets the Medicaid criteria for Nursing facility level of care, and who has a medically based mental health disorder or diagnosis and has a high level resource use in the Nursing facility not currently recognized in the case mix system.

To qualify for a behaviorally challenging patient "add on" the provider must document that the patient involved meets the following criteria:

- The resident meets the criteria for Nursing facility level of care as found in the Utah Administrative Rule: Nursing Facility Levels of Care, R414-502
- The resident has a primary diagnosis which is identified with the appropriate ICD9 code on the MDS as listed.
  - ICD9-331, Alzheimer's Disease
  - ICD9-290, Dementia Other than Alzheimer's. This can include organic brain syndrome (OBS), chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurological disease other

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that Alzheimer's (e.g., Picks, Creutzfeld-Jacob, Huntington's disease, etc.)
- ICD9-854, Traumatic Brain Injury (TBI)

- And, the resident has a history of regular/recurrent persistent disruptive behavior which is not easily altered evidenced by one or more of the following which requires an increased resource use from Nursing facility staff:
  - The resident engages in wandering behavior moving with no rational purpose, seemingly oblivious to their needs or safety
  - The resident engages in verbally abusive behavioral symptoms where other are threatened, screamed at, cursed at.
  - The resident engages in physically abusive behavioral symptoms where other residents are hit, shoved, scratched, and sexually abused.
  - The resident engages in socially inappropriate/disruptive behavioral symptoms by making disruptive sounds, noises, screaming, self-abusive acts, sexual behavior or disrobing in public, smearing/throwing food/feces, hoarding, rummaging through others belongings
  - The resident engages in behaviors that resists care by resisting medications/injections, Activities of Daily Living (ADL) assistance, or eating

- And, The Nursing Facility staff shall have established behavior baseline profile of the resident following R414-502-4 (6)(a) through (g) guidelines and implemented a behavior intervention program designed to reduce/control the aberrant behaviors, and a specialized document program that increases staff intervention in an effort to enhance the resident's quality of life, functional and cognitive status.

It should be noted that any MR/DD residents who are receiving the specialized rehabilitation services (SRS) add on rate will be excluded from receiving this add on rate.

Facilities that document patients that have behaviorally challenging problems as defined above will be paid a "add- on" rate as described in §930.

921 RUGs – NURSING COMPONENT
The Resource Utilization Groups (RUGs) is a severity-based payment system. A facility case mix system is employed in the computation of the RUGs component of the per diem payment rate. Case mix is determined by establishing a RUGs weight for each patient. Available RUGs scores for each patient are combined with the scores of all other patient to establish a composite weight for all patients in the facility. The composite weight is multiplied by a dollar conversion factor to arrive at a per diem amount for the facility payment rate. The "dollar conversion factor" is defined as the rate established yearly by the state that is determined as a result of consideration of the average case mix changes and the necessary resources to maintain proper care levels for the patients. For all practical purposes this is a rate which having been established in the initial year commencing January 1, 2003, will be updated to recognize proper increases necessitated by normal cost increases. The initial case mix or "dollar conversion factor" established on January 1, 2003 was set at $52.55 ppd. The entire rate on average for all facilities utilized on this date was therefore composed of the three

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components; property component, the case mix component and flat rate component which is outlined as follows:

Components as of January 1, 2003
(initial period of the new case mix payment system)
Property Component: $11.19
Case Mix Component: $52.79
Flat Rate Component: $41.57
Total Average Rate: $105.55

Example: a rate determination of facility A-1 Care (hypothetical) which had a case mix or severity index of .8154 and a qualified property amount of $11.19 ppd (minimum granted) is as follows:

Property Payment ppd.:	$11.19
Case Mix Component:	
Index x Case Mix Component ppd:	
Or .8154 x $52.79	$43.05
Flat Rate Component ppd:	$41.57
Total Rate	$95.81

Please note that urban / rural adjustment was not considered in this example as this was presented to demonstrate the use of a case mix adjustment on the rate only.

For the period January 1, 2003 through June 30, 2004, the facility case mix will be calculated quarterly resulting in quarterly rate setting.

922 FLAT RATE – NON-NURSING COMPONENT
The flat rate is a fixed amount paid for all Medicaid patients. The flat rate category is increased periodically for inflation. The flat rate component includes: (1) general and administrative, (2) property and related expenses (net of the property differential), (3) plant operation and maintenance, (4) dietary (including dietary supplements), (5) laundry and linen, (6) housekeeping, (7) ancillary nursing costs separate from nursing salaries, wages and benefits paid under RUGs, and (8) recreational activities. The flat rate established in the first year of the severity based payment project commencing January 1, 2003 reflects the proportion of the overall nursing home rate that is considered to not be variable in nature. The base year or initial year flat rate commencing January 1, 2003 was determined to be $41.57 ppd.

923 PROPERTY (BASE AND DIFFERENTIAL)
All patient per diem rates includes $11.19 in the flat rate component based on historical property payments. Some providers receive a property differential in their per diem rate. The property differential is the amount between $11.19 and the $20.00 ceiling. While many of the nursing facilities will not qualify because their property costs are below $11.20, others will receive between $.01 and $8.81 per day based on allowed property costs reported on the FCP above $11.19 per day. The $11.19 per day was based on $8.66 in the FY 1995 rates inflated to $11.19 for FY 2003 rates.

In determining the amount of the property differential, the calculated cost per day is

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reduced when occupancy is below 75%. Property cost allowed on the 2001 FCP is divided by the greater of 1) reported patient days or 2) licensed beds times 365 days times 75%.

924 NEW FACILITIES
Newly constructed facilities are paid the average per diem base rate. This average rate will be paid for up to six months at which time, the provider's case mix index will be established. A new prospective rate will be paid. Thereafter the property payment to the facility will be controlled by R414-504-3(5).

An existing facility acquired by a new owner will continue with the same per diem payment rate (same case mix index and property component established for the previous ownership.)

925 PROPERTY PHASE-OUT
Property payments will be phased out by reducing the payment by 25% of the January 1, 2003 amount for each of the succeeding three calendar years, with all property payments being phased out effective January 1, 2006.

926 UNDERSERVED AREAS
When the Medicaid agency determines that a facility is located in an underserved area, or addresses an underserved need, the Medicaid agency may negotiate a payment rate that is different from the case mix index established rate. This exception will be awarded only after consideration of historical payment levels and need. A "underserved area" is defined and determined by the following criteria (which includes operational information concerning state procedures):

[ ] (a) A sole community provider that is financially distressed may apply for a payment adjustment above the case mix index established rate.
(b) The application shall propose what the adjustment should be and include a financial review prepared by the facility documenting:
(i) the facility's income and expenses for the past 12 months; and
(ii) steps taken by the facility to reduce costs and increase occupancy.
(c) Financial support from the local municipality and county governing bodies for the continued operation of the facility in the community is a necessary prerequisite to an acceptable application. The Department, the facility, and the local governing bodies may negotiate the amount of the financial commitment from the governing bodies, but in no case may the local commitment be less than 10% of the state share required to fund the proposed adjustment. The applicant shall submit letters of commitment from the applicable municipality or county, or both, committing to make an intergovernmental transfer for the amount of the local commitment.
(d) The Department may conduct its own independent financial review of the facility prior to making a decision whether to approve a different payment rate.
(e) If the Department determines that the facility is in imminent peril of closing, it may make an interim rate adjustment for up to 90 days.
(f) The Department's determination shall be based on maintaining access to services on and maintaining economy and efficiency in the Medicaid program.

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needed" basis.

931 SPECIALIZED REHABILITATION SERVICES (SRS) FOR INDIVIDUALS
An amount is added to the facility rate that pertains to approved patients. Because the SRS rate is paid in addition of the facility specific rate, the resulting revenue is offset against the nursing costs on the FCP.

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(g) If the facility desires an adjustment for more than 90 days, it must demonstrate that:
(i) the facility has taken all reasonable steps to reduce costs, increase revenue and increase occupancy;
(ii) despite those reasonable steps the facility is currently losing money and forecast to continue losing money; and
(iii) the amount of the approved adjustment will allow the facility to meet expenses and continue to support the needs of the community it serves, without unduly enriching any party.
(h) If the Department approves an interim or other adjustment, it shall notify the facility when the adjustment is scheduled to take effect and how much contribution is required from the local governing bodies. Payment of the adjustment is contingent on the facility obtaining a fully executed binding agreement with local governing bodies to pay the contribution to the Department.
(i) The Department may withhold or deny payment of the interim or other adjustment if the facility fails to obtain the required agreement prior to the scheduled effective date of the adjustment.
(j) The additional payment provided to a facility as a result of this provision may not exceed the reasonable and documented cost of providing the services involved. Additionally, the additional payment may not be less than the cost of providing at a minimum the "variable" or incremental cost involved in providing the service.

927 RATE DISAGREEMENTS
Providers may challenge the established payment rate pursuant to this SPA amendment using the appeals process set up by R410-14. Providers must exhaust administrative remedies before challenging rates in State or Federal Court.

928 WAGE INFLATION DIFFERENTIAL
Nursing salary costs (RUGs rate component) will be adjusted by the urban / rural inflation differential. The wage index adjustment compares the average cost of nursing per day in urban and rural areas. Urban and rural areas are defined in Attachment 4.19-A Section 110 of the State Plan. Urban areas include Washington, Utah, Salt Lake, Davis, Weber and Cache counties. These are officially recognized Standard Metropolitan Statistical Areas (SMSAs) as designated by Centers for Medicare and Medicaid Services (CMS). The remaining countries are designated as rural.

929 LIMITATION ON RATE REDUCTIONS UNDER NEW RUGS
The calculated payment rate will include a hold harmless determination so that no facility will be paid less than $5.00 per day than their rate on July 1, 2002. This hold harmless provision ends on June 30, 2004.

930 BEHAVIORALLY CHALLENGING PATIENT ADD-ON
Behaviorally challenging patients may qualify for a special add-on payment rate. The rate established for the base year of 2002 is considered to be $6.60 per patient day (ppd). This rate was determined after extensive "on site" time studies at providers sites. The study determined that additional time involved by all levels of nursing care for these patients, and applied a average amount per hour. This study will be updated on an "as

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